IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 006233

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	HM
Date of birth:	30 March 2000
Date of death:	10 December 2015
Cause of death:	1(a) Gastric perforation with early peritonitis 1(b) Acute gastric distension and chronic gastritis
Place of death:	Kingsville, Victoria

INTRODUCTION

1. On 10 December 2015, HM was 15 years old when he was found deceased at home by his father. At the time of his death, HM lived with his parents, HS and HA in Kingsville and was a student of Footscray City College (**FCC**).

THE CORONIAL INVESTIGATION

2. HM's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of HM's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of HM including evidence contained in the coronial brief, HM's medical and school records, statements from HM's treating doctors and teachers and responses from the Department of Education (**DET**) and Department of Health and Human Services (**DHHS**). Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

7. On 10 December 2015, HM, born 30 March 2000 was visually identified by his mother HA who signed a formal Statement of Identification to this effect before a member of Victoria Police.

8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Senior Forensic Pathologist Dr Malcolm Dodd from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 11 December 2015 and provided a written report of his findings dated 1 February 2016.

10. The external examination showed a somewhat slim teenager with a distended and hyper resonant abdomen. Despite reports that HM had not washed recently, his body and fingernails were clean.

11. The post-mortem examination revealed over 1250 mL of essentially clear fluid with coarse and randomly dispersed finely divided food particles within the peritoneal cavity.

12. The stomach was distended and at the level of the gastric fundus (anterosuperior surface), there were two discrete areas of perforation. Each perforation measured approximately 15mm in greatest dimension. Dr Dodd commented that the stomach was exceedingly fragile and even gentle handling caused tearing and enlargement of the perforations.

13. Focal areas of early peritonitis were identified in the region of the gallbladder and organs adjacent to the stomach.

14. No other significant naturally occurring disease was disclosed.

15. Histologic examination of the stomach wall showed autolytic changes. The gastric wall also showed focal chronic gastritis and focal transmural acute inflammation with early peritonitis involving the serosa (outer wall).

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

16. Given the finding of chronic gastritis, a Giemsa stain[2] was requested. Due to autolytic change and post mortem bacterial proliferation, *H.pylori* could not be identified with confidence, however Dr Dodd could not exclude its presence.

17. Routine toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other commonly encountered drugs or poisons.

18. Biochemical analysis disclosed mild elevation of sodium and chloride ions at 148 and 125mmol/L[3] respectively. This mild elevation of sodium and chloride is in keeping with a state of dehydration. Creatine levels were within normal limits. Urea was mildly elevated at 10mmol/L.

19. A blood culture was performed. Mild bacteria were isolated, indicating likely contamination at the site of the blood sampling.

20. A peritoneal swab was performed. No polymorphs were identified, however numerous Gram positive and negative bacilli and cocci were identified. The culture produced a profuse mixed growth of enteric flora.

21. The underlying aetiology for the acute gastric distension and rupture remained obscure to Dr Dodd. A literature search disclosed occasional examples of gastric rupture with necrosis following acute gastric dilatation. One paper[4] outlined the case of acute gastric rupture of necrosis following gastric dilatation in a 12-year-old boy. In this case, the rupture and perforation were identified early enough for successful surgical intervention. However, the paper indicated that, although uncommon, the condition appeared to be more frequent in lean individuals, particularly teenagers, some who suffer from eating disorders such as anorexia nervosa and bulimia. These individuals tend to have a low body mass index, and this appears to be a risk factor for this potentially fatal condition.

22. Dr Dodd provided an opinion that the medical cause of death was '1(a) Gastric perforation with early peritonitis; 1(b) Acute gastric distension and chronic gastritis.

23. I accept Dr Dodd's opinion.

[2] Giesma stain is used to identify the bacteria *Helicobacter pylori*, which may lead to gastritis and ulceration.
[3] Reference ranges of 135-143 and 99-107 respectively.
[4] Surgery Today. 2012. 42:997-1000.

Circumstances in which the death occurred

24. At one year of age, HM was diagnosed with a mild global developmental delay and was referred to early intervention services and made good progress. During his primary school years, no issues of concern with respect to his learning or behaviour were raised.

25. HM had a later medical history of depression and possible autism spectrum disorder[5] (**ASD**) but did not receive a formal diagnosis for the latter prior to his death.[6] In the last two years of his life, HM missed many days of school and his personal hygiene suffered.[7] He often stayed up until 4am or 5am playing on his computer and would either arrive at school late, or not at all. Explanations provided to FCC mostly attributed HM's absences and late arrivals to sleeping in or not feeling well.[8]

26. He spent much of his time isolated in his bedroom, which he often locked, and typically did not share meals with his family. Instead, a tray of food would be left outside his bedroom door. HM often skipped meals. He sometimes spent many hours locked in the toilet and would not answer when his parents called out to him. HS reported that HM sometimes fell asleep on the toilet because he was so tired. On one occasion, HM was in the toilet for two hours and when his father broke in, he was found reading magazines.

27. Irene Alexandrou, a Student Wellbeing Coordinator (**SWC**) at FCC made a notification to the DHHS on 20 March 2015 that concerned HM's poor school attendance and poor personal hygiene. FCC had observed that HM often stacked and re-stacked his books in a ritualistic way outside of class and had no obvious friendship group. He was generally socially isolated and often walked around the school or went to the library by himself. Ms Alexandrou felt that HM often looked lethargic and unkempt. Another SWC Ross Cornell reported that HM was always respectful to others and got along well with adults.

28. HM was taken to several general practitioners (**GP**) and to a psychologist Dr Helen Thomas. In March 2015, Consultant Paediatrician Dr Raj Khillian reviewed HM and commenced him on the antidepressant Lovan. A referral to a psychologist for cognitive behavioural therapy and assessment for ASD was made as well as a recommendation that HM's parents liaise with his school to arrange a speech and cognitive assessment.

[5] ASD features included an unusual affect (flat affect, monotonous speech), being fidgety while talking, pedantic speech, poor organization skills, poor personal hygiene, restrictive eating habits and a fixation with computers.
[6] At the time of his death, ASD was suspected by HM's paediatrician, school and private psychologist.
[7] sh reported that his son had not showered for three months prior to his death.

29. HM's behaviour had improved by May 2015. He was sleeping well with the help of Catapres 100mg and Lovan 20mg was felt to have been helpful. HM was still refusing to attend school and had not showered for the last month. He did not attend a follow up appointment with Dr Khillian on 12 June 2015.

30. When Dr Thomas reviewed HM on 8 August and 22 August 2015,[9] she suspected ASD and possible obsessive-compulsive disorder. She concluded that she could not provide for HM's ongoing management due to his multiple and complex needs and that he required more intensive assessment and treatment. Dr Thomas referred HM for an ASD assessment through Bloom Child Psychology[10] or the Krongold Centre[11] as well as making a referral to Headspace.[12] HM refused to attend the appointment with Headspace. Dr Thomas also contacted Ms Alexandrou and recommended that FCC arrange an assessment by the school psychologist.

31. Thereafter, Dr Thomas encountered difficulties communicating with HM's family and accordingly, sent her recommendations under cover letter to his parents on 19 September 2015 as well as to HM's GP and Dr Khillian.

32. In the week preceding his death, HM did not attend school and, according to his parents, only left his room to go to the toilet or to eat.

33. On 8 December 2015 HM ate a full meal of the chicken, mashed potatoes and salad that had been left outside his room. Later, he ate some 'Barbeque Shapes' crackers and some 'Drumstick' ice creams. He did not mention felling sick or unwell to his father.

34. The following day, 9 December 2015, HM vomited for much of the day and did not eat anything. He remained in his bedroom, which he locked as usual. That evening, HS heard HM walking between his bedroom and the toilet and drinking water. At about 9:30pm, HS asked HM if he wanted something to eat but received no response. HS unscrewed the lock on HM's door to check on him and found he had vomited on the bed, the floor and in a bucket and complained of not feeling well. HS fetched his son some paracetamol and told him to go to the toilet in case he needed to vomit again.

[9] This was the last date HM engaged with a health professional.
[10] This assessment would have cost $900 with some Medicare rebates available.
[11] This is a subsidised service through Monash University. An assessment would have cost $583 with some Medicare rebates available.
[12] Headspace provides health services and mental health support to 12-25 year old's for free or at a low cost.

35. At about 5:30am the next day, HS checked on HM in the toilet. While HM did not respond, HS thought he heard leg movements and assumed he had woken him up.

36. Sometime after 8:00am, HA called out to HM, who did not answer her. HA was not alarmed due to his history of ignoring his parents and spending time on the telephone playing games on his phone. HM did not answer when HA called out to him again at about 10:00am and again midday but she felt this was not unusual.

37. At 4:45pm, HS returned home from work and used a screwdriver to open the toilet door. HS found HM sitting on the toilet, deceased. Ambulance Victoria paramedics attended but did not render active treatment as it was apparent that HM was deceased.

CORONERS PREVENTION UNIT REVIEW

38. I asked members in the Coroners Prevention Unit[13] that comprised a paediatric registrar and a mental health investigator (**MHI**) to review HM's medical history and assess the systems barriers (if any) to treatment for his suspected ASD.

Spontaneous gastric perforation and acute gastric distension

39. According to the CPU paediatric registrar, reports of spontaneous gastric perforation secondary to acute gastric distension in children are extremely rare and there are only a small number of such case-reports in the medical literature.

40. Patients with anorexia nervosa or bulimia nervosa are known to be at an increased risk of acute gastric dilatation and subsequent possible perforation due to decreased gastric motility. There was no evidence to suggest that HM suffered from anorexia or bulimia, however, similar mechanisms may have been relevant here as his eating patterns were dysfunctional. HM was reported to have a poor appetite and limited food intake in the months preceding his death. There may have been similar underlying mechanisms of decreased gastric motility or gastric muscle atrophy occurring and hence increasing his risk of acute gastric distension.

41. There was nothing in HM's medical records to suggest that he had a history of gastric problems or risk factors that could predispose him to gastric perforation. There was also

[13] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

limited information regarding associated symptoms such as acute abdominal pain. The paediatric registrar posited the theory that this was because HM did not report symptoms to his parents. Proximate to his death, HM did not indicate he was unwell and ate dinner on both 7 and 8 December 2015, according to his parents.

42. Given the lack of prior symptoms, HM's gastric perforation and gastritis could not have been predicted or prevented. The paediatric registrar noted that the underlying cause of HM's gastric perforation, gastric distention and gastritis is ultimately unknown.

Autism diagnosis and its assessment

43. Autism is diagnosed through assessment, which involves observing and meeting with the individual, their family, carers and service providers. Collateral information about the individual's strengths and challenges is sought.

44. The criteria for a diagnosis of ASD are described in the Diagnostic and Statistical Manual for Mental Disorders (DSM-5).[14] Management of ASD focuses on early intervention. Early diagnosis followed by individualised and collaboratively developed programs and supports in early intervention provides the best opportunities for a child to reach their potential.

45. Assessment requires a multi-disciplinary approach via assessment with a paediatrician or child psychiatrist as well as allied health professionals such as psychologists and speech pathologists. In some cases, ASD can be diagnosed without a multidisciplinary assessment when the presentation is severe or when a child clearly meets the diagnostic criteria. In the case of HM, due to his complex and late presentation, a multidisciplinary approach was necessary.

46. The MHI commented that access to ASD assessments in a public multidisciplinary clinic involves lengthy wait times and a limited number of public clinics. Often the wait time is a year or more for an initial assessment. This means that ASD diagnoses are often done privately in collaboration with multiple health services and are costly.

[14] Persistent deficits in social communication and social interaction across multiple contexts; restricted, repetitive patterns of behaviour, interests of activities; symptoms must be present in the early development period and must cause clinically significant impairment in social, occupational, or other areas of important functioning; and these disturbances are not better explained by intellectual disability or global developmental delay.

School responsibilities in the diagnosis of ASD

47. The Executive Director of the Department of Education and Training (**DET**), Lucy Toovey, provided a comprehensive statement and other documents that detailed a school's responsibilities and the systems in place to arrange an assessment for suspected ASD. Ms Toovey also addressed what the responsibilities of schools are when a student is repeatedly absent without explanation.

48. A secondary student with a suspected ASD initially requires the consent of a parent or guardian to arrange an assessment. The ASD assessment can be coordinated by the DET's Student Support Services (**SSS**). The SSS is a multidisciplinary team that includes psychologists and speech pathologists, but not a child psychiatrist or a paediatrician. Accordingly, the parent of guardian must always pursue an external referral to address that gap. The SSS are not obliged to coordinate the ASD assessment process.

49. Once a child receives an ASD diagnosis, schools must consult with the student and professionals to ascertain what adjustments the child needs to participate in their education in the same way as the other students.[15] Supplementary funding is available for students with high needs via the Program for Students with Disabilities (**PSD**). HM would not have qualified for this program as he did not have significant language deficits. However, the school would have still had obligations under the Disability Standards to support him.

50. It was apparent to the MHI that Ms Alexandrou and Mr Cornell thought HM might have had ASD and did consider arranging part of the ASD assessment through the school. Indeed, Mr Cornell met with Susie Webster the Department Student Support Services Officer Psychologist on 21 July 2015 to discuss HM being assessed for ASD. Ms Webster assessed that HM had good language skills and did not consider he met the criteria for additional funding for an ASD assessment, presumably via the PSD. As there were concerns about accessing funding, FCC did not arrange for HM to have a psychology assessment for ASD. Despite Dr Khillian's recommendation to the school that HM undergo a speech and cognitive assessment, FCC did not appear[16] to have made an application to access those assessments. While these additional assessments would have likely aided in the diagnosis of ASD, the MHI observed that the school did encourage HM's family to pursue these services privately.

[15] This obligation is provided for in state and federal legislation, including under the *Disability Standards for Education 2005*.

[16] None of the four FCC staff members mentioned that recommendation in their statements.

Management of HM's wellbeing and attendance rate

51. A notification to DHHS was appropriately made on 20 March 2015 about HM's poor school attendance and poor personal hygiene. DHHS recommended that Ms Alexandrou refer HM to Child FIRST[17] for parenting support. [18] However, as Child FIRST were full and not taking new referrals, they recommended HM see a private psychologist and that FCC make a new referral when Child FIRST could take on new clients. The DHHS Child Protection service assessed that HM was not at significant risk of harm and the case was closed at intake.

52. Ms Alexandrou attempted to make a referral to the Bouverie Family Therapy Centre, but they also had a long waiting list. Efforts to engage a Turkish-speaking family support worker through the local council also proved fruitless. In the absence of external services being available, the SWC's at FCC made appropriate efforts to engage with HM and his parents. They met regularly with HM and his father and provided advice in respect of improving HM's sleep and encouraged the family to seek psychological support. Ms Alexandrou also appropriately escalated her concerns with DHHS and tried to locate family supports for HM's family.

53. FCC had several meetings with HM's parents about his late attendance or non-attendance at school and the school attendance officer made several visits to the family residence. HM's Year 10 coordinator Elizabeth Simpson reported that HS agreed with all her recommendations, but HM essentially ignored them. Overall, the MHI concluded that FCC appeared to have taken the appropriate measure to address HM's school refusal and tardiness, including arranging meetings with his parents and making a referral to DHHS.

Conclusion

54. The MHI considered that HM's probable undiagnosed ASD contributed to his decline in mental health in the year leading up to his death. They also considered it likely that it contributed to the development of depression, social isolation, school refusal and poor personal hygiene.

55. Although the cause of HM's gastric symptoms is unknown, his poor mental health proximate to his death contributed to the delay in recognition of his acute illness. In the months prior to

[17] Child FIRST (Child and Family Information, Referral and Support Teams) are the entry point into family services. They are located throughout Victoria and are delivered by community service organisations. Support programs include Family Services and Early Parenting Centre Services.

[18] A single case note identified that consent to engage with Child FIRST was not obtained due to a language barrier and that Ms Alexandrou would gain consent for a referral to Child FIRST using an interpreter.

his death, HM had repeatedly refused to see medical professionals and had limited interaction even with his parents with whom he lived. He did not tell his parents he was unwell, and his acute illness was only recognised when his father forced entry into his room and found he had vomited. The MHI commented that both depression and sensory changes due to ASD may have contributed to HM's under reporting of his symptoms. That is because some people with ASD have altered sensitivity to pain and can sometimes seem insensitive to pain.

56. It appeared to the MHI that the health professionals involved in HM's care made the appropriate referrals and recommendations for an ASD assessment and psychology support. However, these could not be actioned due to multiple barriers specific to the H family that prevented access. The diagnosis of ASD, particularly in older children, often takes a significant amount of time due to prolonged wait lists. Assessments can also be extremely costly. Based on the MHI's current clinical experience, little has changed in relation to accessing ASD assessments in the community and the barriers listed as at 2015 still exist now.

57. The MHI considered that FCC took appropriate action to address HM's poor attendance and support his wellbeing. However, they could not arrange additional assessments (ASD assessment, speech assessment or cognitive assessment) for HM due to lack of funding. HM's family were recognised as needing additional support to action these recommendations, but no additional support was available.

58. The MHI opined that HM's case is an example of multiple system barriers across multiple sectors for children to access the appropriate diagnostic services and families to access the appropriate support services.

59. Ultimately, while the MHI did not identify any opportunities for prevention, they did identify the need for systems improvements.

Department of Education and Training

60. Upon receipt of the CPU's advice, my solicitor wrote to The Department enquiring about how they might best support students on, or suspected to be on, the ASD spectrum.

61. In their first response, The Department provided extensive background information about the programs and projects undertaken by the Victorian Government since 2015, including funds spent and an overview of the programs aimed at providing inclusive education.

62. In their supplementary response, The Department indicated it has implemented a specific division to focus on the inclusion of children with disability and additional needs and noted the previous barriers to accessing funding for assessments.

63. In 2018 a program was piloted that piloted a functional, needs based assessment program for children with disability. In November 2020, the Victorian Government launched their Disability Inclusion package. This package transformed support for students in public schools. Disability Inclusion will invest nearly $1.6 billion in additional supports to assist Victorian Government schools in improving their education practice and the inclusion of students with disability.

64. Beginning in 2021, Disability Inclusion will provide government schools with supports concerning training, advice, professional learning and resources about inclusive education. There will be a progressive five-year roll-out of functional needs-based funding and a Disability Inclusion Profile to better support students.

65. As part of the roll-out program, a new, functional needs-based funding approach will be implemented. This will include a tiered funding model with additional funding to schools to help students gain parity with their peers. The new model is based on a structured approach to funding that considers the diverse needs of students with disability and replaces the existing Program for Students with Disability. The tiered funding model will provide schools with additional school-level funding[19] to support students with disability who do not qualify for individual funding.

66. Each student will have a Disability Inclusion Profile. It will encapsulate a student's educational objectives, their needs and the adjustments required to enable them to participate and engage in their schooling. It is a strengths-based process that assists schools and families in identifying and responding to the needs of students with disability. The Profile will inform individual and school-wide planning and funding allocations for students with high needs.

67. A workforce of Disability Inclusion Facilitators[20] will be employed to help schools and families work together. These individuals will essentially support and provide guidance with the process of identifying and addressing individual and school-wide requirements.

[19] School level funding will mean schools can fund adjustments including additional training and professional development, access to expertise in disability, extra teachers or staff to help plan and deliver adjustments and equipment and resources to support learning.

[20] They will be qualified professionals with experience in inclusive education, such as allied health professionals and teachers with special education experience or training.

68. Implementing these measures over a five-year period will enable school systems to manage the changes, including employing new workforces and transitioning to new policies and procedures. To ensure that all schools and students begin to benefit from Disability Inclusion as soon as possible, elements of Disability Inclusion will be rolled out in 2021. From mid-2021, new resources and initiatives[21] will be introduced to better support students, including those with autism.

69. Within the broader Disability Inclusion package is the Victorian Autism Education Strategy (**VAES**).[22] This aims to improve educational outcomes and support for autistic students and foster inclusive school communities. It also appreciates that additional, targeted supports are required to assist autistic students with their education.

70. The Strategy was developed in concert with experts, researchers, autism advocacy organisations and autistic students and their families. Six priority areas were identified:

    a) To promote and celebrate autism inclusion and diversity at a school level;

    b) To build the capability of school leaders and staff to meet the educational needs of autistic students;

    c) To involve the student, families and experts to collaboratively plan the students' education;

    d) To support autistic students' health and wellbeing;

    e) To support autistic student's individual education needs; and

    f) To strengthen accountability and transparency for students with disability.

71. The Strategy will also include new and expanded initiatives to assist the learning needs of autistic children.

72. Another element of the strategy is the establishment of a Diverse Learners Hub. The Hub will be established to cater to students with neurodevelopmental differences such as autism, dyslexia, dyscalculia and Attention Deficit Hyperactivity Disorder. It will begin operating in

[21] Including more experts in disability in schools, coaching for school leaders, additional training and learning, evidence-based guidance and resources and scholarships for school staff.

[22] Governance of the VAES lies with the Victorian Government and applies across all departments including the DET, DHHS and the Department of Justice and Community Safety and addresses access to publicly funded assessments.

2021 and will coach school leaders and provide evidence-based resources to schools and families. The Strategy will support specific initiatives to assist autistic students.[23]

FINDINGS AND CONCLUSION

73. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was HM, born 30 March 2000;

    (b) the death occurred on 8 December 2015 at Kingsville, Victoria,

    (c) the cause of HM's death is 1(a) Gastric perforation with early peritonitis; 1(b) Acute gastric distension and chronic gastritis; and

    (d) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

74. The Victorian Autism Plan provides a considered approach to reducing the barriers to assessment and appropriate education and support and improving the experiences of people who are diagnosed with an autism spectrum disorder, as well as their families and friends. Its focus on early diagnosis results in better outcomes for autistic people but it is often schools that are first to identify concerns. Schools having clear pathways in place, including working with parents, enables timely access to specialist assessment that is not prevented by lack of funding.

75. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

76. I direct that a copy of this finding be provided to the following:

    HS and HA, Senior Next of Kin

[23] Improved Student Support Group and Individual Education Plan resources for schools to provide more consistent and high quality support for autistic students; learning initiatives for teachers to complete post-graduate studies in inclusive education, including at the Autism Teaching Institute; professional learning modules; the I CAN mentoring program (providing targeted emotional/social support and mentoring for autistic students); Disability Friendly Schools to promote a supportive and inclusive approach to prevent bullying of students with a disability, particularly those with autism; and collaborations with key partners such as Amaze and Yellow Ladybugs to develop resources for autistic students, their families and schools,

The Secretary, Department of Health and Human Services

The Secretary, Department of Education and Training

The Proper Officer, Footscray City Secondary College

Detective Senior Constable Brett Van Der Vliet (#34512), Coroner's Investigator

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 29 June 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.